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ABSTRACT

A case study approach was used to examine the complexities of service utilization in early intervention with infants, toddlers, and young children with disabilities. Seventy-two families of children (ages birth to 4) participating in nine early intervention programs in three states (Colorado, North Carolina, and Pennsylvania) and their service providers completed a self-report questionnaire and were interviewed. In addition, documents (the Individualized Family Service Plan or the Individualized Education Program and the latest assessment report) were analyzed. Results are reported in terms of families' service use and professionals' provision of services, including family characteristics, family-service provider relationships, African American mothers, support families received, families' reflections, and service providers' reflections. Overall, findings suggest that professionals' provision of services reflects: (1) a predominant child versus family orientation; (2) a generally positive approach to families; (3) a disjointed and segregated way of working with other professionals; (4) reasonably effective coordination of existing services; (5) poor provision of information about resources outside the formal early intervention/preschool programs; (6) a heavy reliance on therapists; and (7) dependence on direct, hands-on treatment for short periods. (Contains 28 references.) (DB)

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Early Childhood Research Institute on Service Utilization

Using and Providing Services: Case Studies in Early Intervention

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The University of North Carolina
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An Institute for the Study of Education, Health Care, & Social Service Utilization of Infants, Preschool Children, and Their Families

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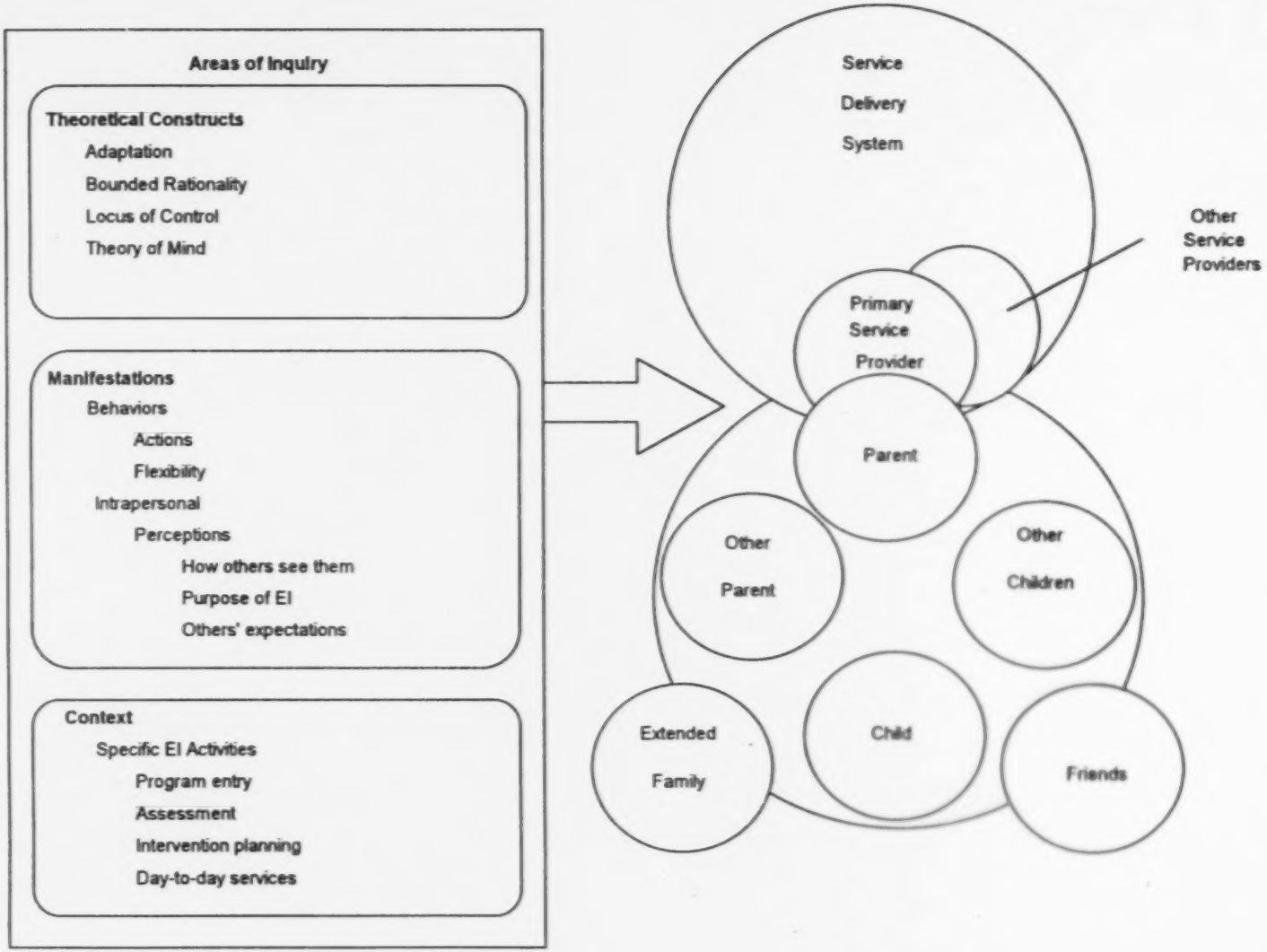
Using and Providing Services: Case Studies in Early Intervention

R. A. McWilliam, Lynn Tocci, John Sideris, and Gloria L. Harbin

A large set of case studies was undertaken to discern the complexities of service utilization in early intervention. The conceptual framework guiding these case studies is depicted in Figure 1. The parent is at the heart of the interaction between the service delivery system and the family. The relationship between the parent and the primary service provider was a critical research focus, and this *relationship* is shown by the overlapping circles for these two people. The parent is part of a family unit that includes the child who has been identified as needing services, possibly another parent, and possibly other children. Linked to the family are members of their informal support network, including extended family and friends. The primary service provider is joined by other service providers working with the family, all of whom are part of the service delivery system.

Theoretical constructs. Our areas of inquiry began with theoretical constructs of adaptation, bounded rationality, locus of control, and theory of mind. As the study progressed, we found that some of these constructs were actually inapplicable, but it is important to report the framework with which we began the case studies. *Adaptation* theory (McCubbin & Patterson, 1982) postulates that individuals change their behavior to accommodate to the demands of their environment. In particular, we were interested in the adaptations families and service providers must make in terms of their relationships with each other and with the service delivery system. *Bounded rationality* theory (March & Olsen, 1984) is used to explain the phenomenon of a


Areas of Inquiry
Theoretical Constructs
Adaptation
Bounded Rationality
Locus of Control
Theory of Mind
Manifestations
Behaviors
Actions
Flexibility
Intrapersonal
Perceptions
How others see them
Purpose of EI
Others' expectations
Context
Specific EI Activities
Program entry
Assessment
Intervention planning
Day-to-day services
Service
Delivery
System
Other
Service
Providers
Primary
Service
Provider
Parent
Other
Parent
Other
Children
Extended
Family
Child
Friends

Person's limiting his or her reasoning as a result of the limitations in the environment. For example, families who make do with substandard child care might do so because those are the only options in their community (Holloway & Fuller, 1992). We were particularly interested in the extent to which families' perceptions might be limited by the services they are offered and in the extent to which professionals' self-defined roles might be limited by the structure of the system in which they work. *Locus of control* refers to an individual's perceptions about who has power to influence and change events in his or her life. We looked for evidence of internal or external locus of control in both families and service providers. The case studies were designed to build upon data gathered through locus of control scales administered to the large sample. *Theory of mind* is the term for the ability to perceive something from another perspective. Although this theory is most often used in child development, we were interested in applying it to an examination of whether families and service providers were able to see things from the other's perspective. This theory is related to the theory of mutual adaptation in policy implementation.

Manifestations. In the course of the interviews, we looked for descriptions of families and service providers' behaviors and interpersonal actions. We listened to interviewees for descriptions of actions they had taken and (particularly from service providers) flexibility they had displayed. We also listened for their perceptions of how others saw them, why they were engaged in early intervention endeavors (as consumers or providers), and what they thought other people expected of them. Data analysis included verification checks (e.g., to see whether a family's perception of what their primary service provider thought of them matched what the service provider said about the family).

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Context. The context in which we made our inquiry was specific early intervention activities. We probed for information about specific practices and experiences at the time the family entered the early intervention program, at the time(s) of assessment, at the time(s) of intervention planning, and during day-to-day services.

In summary, from the context of our inquiry we looked for manifestations of theoretical phenomena related to service use and service providers' characteristics. The stories we heard were expected to reveal within-case and across-case patterns about relationships between families and service providers, service providers and service delivery systems, families and service delivery systems, and the three-way interaction of families, service providers, and service delivery systems.

Method

Participants

Case study families were selected from a larger sample of families[1] (N = 300) participating in an early childhood research institute (Harbin & Kochanek, 1993). The full sample of families was recruited through nomination from early intervention professionals in three states, Colorado, North Carolina, and Pennsylvania. These three states were selected because they differed in their early intervention policies, the contexts in which services are provided (i.e., how services are configured), community demographics (including economics), and geography (West, Southeast, Rust Belt). From the full sample, a stratified purposeful (Patton, 1990) sample of 72 families participated in the case studies. Two types of participants were involved in the case studies, family members and their service providers.

The selection involved identification of 72 children[2], ages birth to 4 years, in nine communities across the three states. The communities were chosen to obtain a diverse sample within each state: one community of high population density, one of medium population density and one of low population density. Various demographic variables were used to ensure the representativeness of the children and families.

As we enrolled volunteer families into the study, we asked the parents or guardians who they considered their primary service provider. We then called that person and invited her—they were all women—to participate in the study. Almost 100% of all family members and service providers invited to participate did so. Participating service providers ($N = 43$) consisted primarily of early childhood special educators, therapists, and social workers. Almost all ($n = 41$) the professionals were Caucasian.

Procedures

The primary data sources were interview transcripts. Family interviews were conducted live, whereas service provider interviews were conducted by telephone. The following description provides details about the data collection and other procedures.

Family Interviews

Case study data consisted of in-depth face-to-face interviews with families and their service providers, assessment reports, and individualized plans. Almost all interviews were conducted by two researchers who had worked together to use similar interview approaches.

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[1] "Families" includes the children in those families.

[2] Seventy-five families were interviewed the 1st year, when we oversampled to protect against attrition.

They followed interview semi-structured protocols, described later. After families were recruited through professionals, as described above, and gave consent, researchers interviewed them face to face. Families chose the location of the interview, which was usually the family's home. Two interviews were conducted with each family, 1 year apart; interview instrumentation is described below. The interviews consisted of three types of questions, as described next.

Descriptive questions. We asked broad, open-ended questions about families' use of services. These questions include grand-tour and mini-tour questions; the former are designed to elicit stories (e.g., what a typical day is like), and the latter are designed to focus on a smaller unit of the family's experience (e.g., what home visits are like).

Structural questions. These contain "questions of inclusion" (Gilchrist, 1992), where we sought to expand on areas pertaining to our research focus—use of services. Verification questions are used to prove or disprove our understanding of what aspects are included within the area of interest (e.g., "Do you see the YMCA swimming program you use as an intervention-related activity or do you do it just as recreation?").

Contrast questions. We used these questions to get further clarification and to ask the family to verify differences we thought we understood (e.g., "Do you mean that there's a difference between the way the physical therapist talks to you and the way the occupational therapist talks to you?"). Contrast questions were also used to clarify terms the family used (e.g., "What's the difference between a rude person and a mean person?"). Finally, some contrast questions might be rating questions, where we asked the family to describe the best or the worst experiences they have had in particular areas of service delivery.

The interview guidelines were used to remind the interviewer of important types of information and perceptions we sought. An individualized, iterative process was followed, however; here, earlier statements the family had made influenced the particular questions asked. We returned to the topics of research interest when we felt that either the family had strayed too far from our topics or too much time on nonfocus topics had elapsed. The interview guidelines were iterative in the sense that issues raised in earlier interviews influenced the types of questions asked in later interviews. Because of our ongoing contact with families, we could have returned to ask families interviewed earlier in the process about themes that emerged in subsequent interviews. In the end, we called families back only for particular analyses, such as an analysis of African American mothers' experiences.

Interviews typically lasted 1 1/2 hours, and were audiotaped. In two instances the family requested to not have the interview tape recorded. In these cases, the interviewer dictated field notes after the interview. Taped 1st-year family interviews were transcribed verbatim. Both 1st- and 2nd year family interviews were summarized immediately after each interview, using two data reduction protocols recommended by Miles and Huberman (1994). First, we completed an explanatory effects matrix summarizing information about predetermined variables into an easily readable form. Second, we drew a family support diagram, mapping all the people (extended family, friends, professionals) and services (e.g., Health Department, Social Services) involved with the family. Family support diagrams also indicated how supportive these relationships were to the family. Both the family support diagrams and explanatory effects matrices were returned to families for their review.

Service Provider Interviews

A qualitative approach was employed to answer the question about what we can learn from sensitive service providers about the nature of infant-toddler and preschool services, particularly about family-centered practices. These interviews were conducted after the 1st-year family interviews, which was when we determined who each family's primary service provider (i.e., who to interview) was. We interviewed the service providers by telephone, tape recording the interviews with their consent. Each interview lasted 30-90 minutes.

Written Documents

Once families gave permission, two documents were requested for each child, the IFSP or IEP and the latest assessment report. These were used to verify children's diagnoses. The IFSPs/IEPs were used for analyses under the direction of Dr. James J. Gallagher.

Setting Descriptions

In Year 4 of the Institute, we determined that the different settings where families used services needed to be properly described.

We therefore conducted qualitative observations to gather descriptions of services and to secure a perspective, other than that of parents or professionals, of service utilization. Observations were conducted while case study children or families were receiving the services.

Data Collection

We visited each community and observed the "most significant" services in that community. The significance of services was determined by the number of case study families

using services or by uniqueness of the services. Based on findings to date, we saw the need to observe three types of service settings predominantly: classroom-based, clinic-based, and home-based. Not all service settings were observed in each community, but, across the nine communities, approximately one third of the observations occurred in each service setting. Research staff took field notes, concentrating on aspects of service use such as the parent's role, the focus of the interventionists' activities (e.g., child only, child and family), child engagement, and developmental (e.g., cognitive, language, motor, social, self-help) or family areas addressed. Complete descriptions of the physical environment were made. Following anthropological custom, field notes included attention to nonverbal behaviors.

Self-Report Questionnaires

Procedures for distribution and collection of the self-report questionnaires are described elsewhere in Harbin and Kochanek (1998). Procedures for data entry and preparation for analysis are described in Kochanek and Buka (in press).

Instrumentation

Two types of instruments were used, interview protocols and self-report questionnaires. Details about the interview protocols, including their development, are available from the first author.

Scales

The four rating-scale questionnaires were the Family Support Scale (Dunst, Jenkins, & Trivette, 1984), which measures the amount and helpfulness the family receives from friends, family, formal sources, and informal sources; the Parental Control Scale (modified from the

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Devellis et al., 1985, Child Improvement Locus of Control Scale), which measures parents' attribution of control for their child's future to random, divine, parental, and provider control; the Family Feelings and Emotions Scale, which measures families' positive and negative "affect"; and an abridged version of the Family Beliefs Scale, which measures whether families believe services should be rendered with families' controlling services, professionals' controlling services, or child development needs controlling services.

Analyses

This section is largely limited to the qualitative analytic procedures used with the case studies. Quantitative analyses were also conducted and used in some mixed-method investigations, but those analyses are described elsewhere (see Kochanek & Buka, in press).

Following Miles and Huberman's (1994) model, three streams of analysis activity occurred. First, *data reduction* occurred as we organized transcripts and telephone interview field notes and as we coded transcripts and field notes. Second, *data display* occurred through matrices, graphs, charts, and networks of the extended text data. Third, we *drew conclusions and verified* the data, beginning with our conceptual framework and proceeding in increasingly explicit and grounded (Glaser & Strauss, 1967) ways. Details about the embedded design (see Yin, 1989), sorting categories (for sorting cases into thematic categories), mixed-method analyses (i.e., mixing qualitative and quantitative data), and coding (for data retrieval), are available from the first author or in Harbin and Kochanek (1998).

Specific Analyses

Some analyses had unique characteristics to fit the purpose of the study. Four specific studies were (a) an investigation of family-centered principles, using six service providers; (b) families' perceptions of enhancers and barriers of early intervention (i.e., infant-toddler and preschool) service delivery, after at least 1 year's experience; (c) African American mothers' experiences in early intervention; and (d) a study about the factors predicting the quality of service provider-family relationships. Details about these analyses can be obtained from the first author or in Harbin and Kochanek (1998).

Results

The major findings from 2 years of data collection and 4 years (Years 1-5 of the Early Childhood Research Institute: Service Utilization) of analysis are summarized in two sections: families' service use and professionals' provision of services.

Families' Service Use

Family characteristics were analyzed as explanatory variables for different outcomes of early intervention. We also explored the ***relationship between families and service providers***; this was a central feature of our conceptual framework (see Figure 1). Obviously every family's experience using early intervention services is different. Because fewer than 5% of service providers are African American, we were interested in whether ***African American families*** as a group had different experiences from non-African American families. As we got to know families, the theme of ***support*** emerged, which was consistent with the literature (e.g., Cohen & Wills, 1985; Davis & Rushton, 1991). Families were able to tell us ***what helped and what hindered***

their being able to use services to the fullest. These five analyses constituted the backbone of our findings about families' service use.

Family Characteristics

Four data sources (interviews, scales, case sortings, and demographics) were analyzed and seven major findings emerged from the mixed-method analysis incorporating family characteristics. Results are organized by those outcomes.

1. Families' Reactions to Services

From the interviews, we found that families were extremely positive about their service providers, even when the services those professionals provided did not match the quality of recommended practices in the literature (e.g., Odom, McLean, Johnson, & LaMontagne, 1995). For example, even though home visits were often educational/therapeutic, pull-out services were often used in classroom programs, and clinic-based services were often disconnected from other services, families liked their service providers. Families' feelings about their primary service providers emerged from the interviews and was not assessed through the other methods; interviews were therefore the sole source of this finding.

2. Problems With Transitions

Interviews showed that families are not happy about making a transition of both services and professionals when the child reaches 3 years of age and *preschool* services take over from *infant/toddler* services (a transition propelled by policy, which divides services into these two programs). Families' fondness for their primary service providers is likely to make this transition even harder than it otherwise would be.

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3. Numerous Settings for Services

Another result emerging only from the interview data was that children and families receive services in a variety of settings, and families occasionally have choices about those settings. The research design involving multiple communities allowed us to see different constellations of service systems. The finding that families were given some choice in some programs reflects one aspect of family-centeredness (e.g., Brinckerhoff & Vincent, 1986) and reflects the importance of having a broad-based definition of services (i.e., including formal early intervention services and community resources). This finding is supported by the quantitative data from the large sample (Kochanek & Buka, in press).

4. Focus of Services

Interview data also revealed that, despite policies encouraging a family-focused approach to early intervention, services were predominantly child-focused. In terms of the extent to which services were family-centered, professionals were responsive to families' concerns and priorities but they did not focus on parents' needs. Families expected services to focus on children, as has been discussed in McWilliam, Tocci, and Harbin (1995). Some service providers can be identified as stellar in their family-centeredness, their commitment to providing high-quality services, and in their close relationships with families.

The focus of services was assessed, in addition to interviews, through rating scales, which reveal that Caucasian "working poor" parents believe that child development should be the focus of services much more than do non-Caucasian "working poor" parents, $F(2, 58) = 5.37$, $p = .0073$. Parents in poverty and those with moderate or high incomes, regardless of ethnicity, believe child development should be the focus (i.e., their scale scores approximate Caucasian

"working poor" families'). "Working poor" parents have less of a belief that parents' desires should be the focus of services, compared to the beliefs of moderate- and high-income parents and parents in poverty, $F(2, 58) = 4.92$, $p = .0106$. Parents in poverty have the strongest belief that the system's priorities should be the focus of services, $F(2, 56) = 3.40$, $p = .0403$.

Relationships among sorted groups were established, showing that among families classified as child-oriented (i.e., wanting the focus of services to be on the child rather than on the whole family; $n = 57$), the majority ($n = 48$) had friendly (as opposed to closely bonded, neutral, or negative) relationships with their service providers ($\chi^2 = 20.823$, $p < .0001$), whereas among the few families classified as wanting the focus to be on the whole family ($n = 6$), the majority ($n = 4$) had closely bonded relationships with their service providers.

5. Control Over Services

In analyzing the rating scales by the demographics of the families, we found that, among parents of children who enter early intervention services when they are older, those whose families have the most complex needs prefer much professional control, compared to those with fewer needs, $F(2, 56) = 3.74$, $p = .0299$. On the other hand, among parents of children who enter services when they are younger, the high-needs families prefer the least professional control, and the moderate-needs families prefer the most professional control. Parents of preschoolers, more than parents of infants and toddlers, believe parents should control services, $F(1, 65) = 3.94$, $p = .0512$. This was supported by analyses of the sortings by demographics, where we found that the younger children were, when enrolled in early intervention services, the more likely the family was to be classified as having an internal locus of control (Mantel-Haenszel $\chi^2 = 4.367$, $p = .038$, $\varphi = .27$). These results, together, suggest that a sense of control over services increases over time.

Examination of scales by demographics showed that ethnicity accounted for differences in parents' locus of control: Caucasian parents had more internal locus of control than did non-Caucasian parents, $F(1, 57) = 2.66$, $p = .1083$, d = .43. Caucasian parents attributed more control than did non-Caucasian parents to random forces, $F(1, 57) = 5.14$, $p = .0272$, d = .60. This finding was also supported by our analyses of sortings by demographics: Caucasian families were more likely to be classified as having an internal locus of control than were non-Caucasian families (Mantel-Haenszel $\chi^2 = 7.697$, $p = .006$, $\varphi = .39$).

When we analyzed relationships among sorted groups, we found that the majority of families classified as empowered ($n = 40$) were also classified as having internal loci of control ($n = 26$), and the majority of families classified as unempowered ($n = 20$) were also classified as having external loci of control ($n = 14$; $\chi^2 = 18.246$, $p = .0001$). Furthermore, The majority of families classified as being knowledgeable about early intervention services ($n = 45$) were also classified as have internal loci of control ($n = 29$), and the majority of those classified as having little knowledge of services ($n = 14$) were also classified as having external loci of control ($n = 10$; $\chi^2 = 17.779$, $p < .0001$).

Analysis of sortings by demographics revealed that college-educated parents were more likely to be classified as being empowered, ($\chi^2 = 6.820$, $p = .033$, $\varphi = .334$), having high knowledge, ($\chi^2 = 3.987$, $p = .046$, $\varphi = -.27$), and having an internal locus of control, ($\chi^2 = 9.853$, $p = .007$, $\varphi = .435$), than were high school graduates. Income was also found to affect families' sense of control over services, with high-income families were more likely to be classified as empowered (Mantel-Haenszel $\chi^2 = 5.081$, $p = .024$, $\varphi = .35$), having high knowledge (Mantel-Haenszel $\chi^2 = 4.180$, $p = .041$, $\varphi = .30$), and having an internal locus of control (Mantel-Haenszel

$\chi^2 = 3.834$, $p = .050$, $\varphi = .29$) than were moderate-income families or those in poverty. The last group were the most likely to be classified as being unempowered, having low knowledge, and having an external locus of control. The effects of income on these sortings was not found in the analyses using the locus of control scale.

6. Psychological Well-Being

Analysis of scales by demographics showed that parents' negative feelings, as reflected by their answers to an emotions rating scale, vary by income and race, $F(2, 58) = 2.94$, $p = .0606$, d = .45. Caucasian parents with moderate and high incomes have by far the least negative feelings, and non-Caucasian parents in poverty have the most negative feelings. In contrast, "working poor" non-Caucasian parents have less negative feelings than do "working poor" Caucasian parents.

7. Support

Scales by demographics analyses revealed two findings about support. First, nonwhite "working poor" parents report receiving the least support from friends, compared to other income groups and compared to Caucasian parents, $F(2, 58) = 2.60$, $p = .0825$, d = .42. In contrast, the parents reporting receiving the most support from friends were non-Caucasian parents with moderate and high incomes. Second, families with the most simple needs reported intrafamilial support as more helpful than did families with moderate or complex needs, $F(2, 58) = 5.36$, $p = .0073$. Intrafamilial support was least helpful to families with moderate needs.

These results show how the use of many cases can produce a blending of qualitative and quantitative approaches to data analysis. The findings derived from constant comparative readings

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of the interview transcripts are consistent with traditional grounded treatment of nonnumerical data. The sortings of cases begin with a qualitative approach, in that decisions about sortings are based on interpretive analysis. The resultant groupings are then used both for nonparametric statistics (e.g., (2), for testing for relationships among sorting groups, and for parametric statistics (e.g., ANOVA) for testing for linear relationships between sorting groups (treated as class variables) and continuous rating scale scores. Finally, with a sufficient sample size, traditional statistical tests can be used for examining linear relationships between scale scores and demographic variables. The use of both qualitative and quantitative methods, separately and together, enable researchers both to retain themselves as instruments (i.e., using themselves for the hermeneutic task of interpretation) and to take advantage of numerical instruments and demographic information.

Family-Service Provider Relationships

A seven-variable model is hypothesized to explain variation in the quality of family-service provider relationships. For the sake of brevity, in this section findings are simply listed, with a short explication following.

1. Service providers and families do not have to be alike but it helps.
2. Investment in the family consists of going beyond the call of duty.
3. Investment in the child helps establish and maintain rapport but, when it becomes the entire focus of the intervention, it limits the breadth of the relationship.
4. Training affects how much the service provider is likely to invest himself or herself in the child and family.

5. The amount and nature of the support the professional provides is a product of the investment in the family, which includes the child.

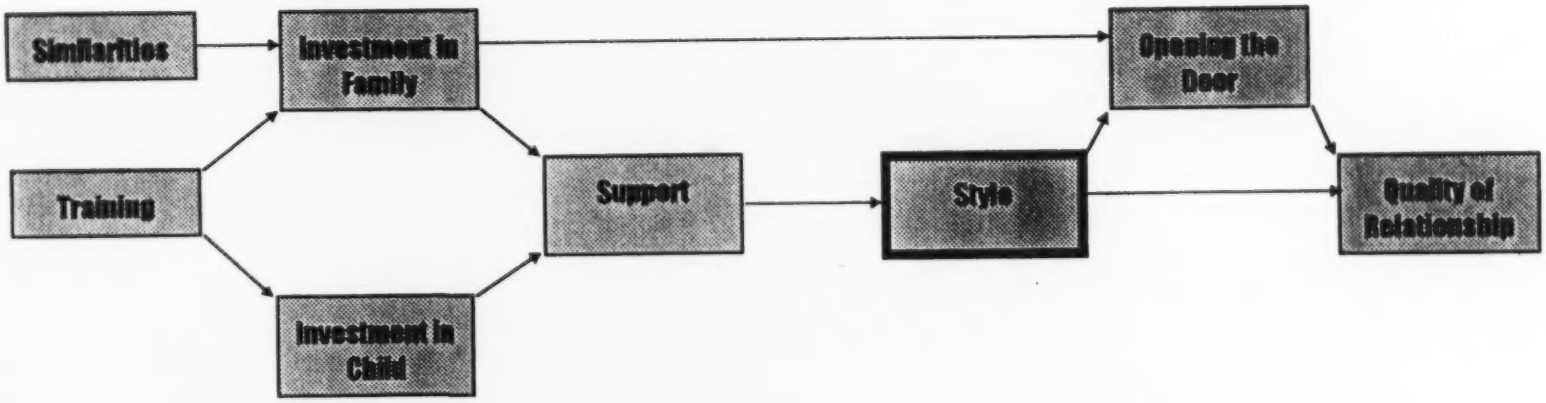
6. The service provider's style or characteristics are the strongest influence over the quality of the relationship, and they are directly or indirectly influenced by the other variables.

7. How much the service provider opens the door to parent-level concerns mediates the effects of many of the other variables and moderates the effects of investment in the family.

Each of the themes emerging from our data analysis is hypothesized to contribute to the nature of service provider-family relationships. Close examination of the data suggest a pattern among these themes, as shown in Figure 2. Families attribute similarities between professionals and parents as a contributor to professionals' investment in the family. It is possible that the more similarities the professional has with a parent the more likely the professional is to invest in the family in the ways described earlier. Meanwhile, the training that service providers have received is hypothesized to account for how much investment the professional shows in the family and the child. Service providers who have received training in family-centered practices, for example, could be expected to invest in the family as well as the child. Both investment in the family and investment in the child are hypothesized to mediate the effects of similarities and training on the support professionals give families. That is, although one might assume that training leads to professionals' supporting families, our findings suggest that (a) it is the amount of investment professionals display that most clearly predicts the amount of support they give families and (b) training has more of an effect on investment in families and children than it does on support behaviors. Support, in turn, moderates the effects of investment on the service provider's style. Although service providers with a high or low investment in the family or a high or low

Figure 2

Factors Influencing the Quality of Family-Service Provider Relationships



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investment in the child have possibly equal chances of possessing a helpful style (as described earlier), the extent to which it contributes to a positive relationship hinges on how much support they provide. The service provider's style is hypothesized to be the most critical predictor of the quality of the relationship, hence its depiction in a bold box in Figure 2.

One other theme, however, plays an important role in the quality of the service provider-family relationship: the extent to which the service provider "opens the door" with the family to parent-related priorities and concerns. The opening the door phenomenon is hypothesized to mediate the effects of investment in the family and service provider style. With respect to style, among professionals with helpful, responsive, and friendly styles, those who have opened the door are those who have the most mutually satisfying and reciprocal relationships with parents. Nevertheless, we came to know numerous families who had excellent relationships with their service providers, even though the latter did not open the door to parent-level concerns and priorities. This finding suggests that highly satisfying or close relationships do not depend on the use of recommended practices. It supports the notion that professionals' styles are the most important predictor, even if professionals do not open the door to family-level needs.

This pattern of linkages among themes provides some structure for a complex set of variables affecting the quality of the service provider-family relationship. It is not necessarily either exhaustive or maximally parsimonious (i.e., some themes should perhaps be merged). Because the linkages can be expressed in terms of moderators and mediators, future research should attempt to measure these variables quantitatively and should test the model with structural equation modeling. The model lends itself to path analysis. One of the challenges for quantitative

researchers, however, is the lack of adequate instrumentation for measuring the variables of interest (e.g., investment in family, style, opening the door).

African American Mothers

Close inspection of a few African American mothers' experiences showed that some received (i.e., conventional) wisdom is supported (e.g., the importance of religion), but some is refuted (e.g., fathers' lack of involvement).

1. Families expressed a positive view of life, despite their children's disabilities.
2. Families were very knowledgeable about their children's disabilities and services.
3. Many fathers were involved, but are not permanent fixtures.
4. Whole networks of kin and friends were involved in helping to raise the children.
5. Religion and the church were important in some families' lives, sometimes for specific supports around the child.
6. Most services were child-oriented, but some families wanted a more family-oriented approach.
7. Families thought highly of their service providers.
8. The service provider's race was unimportant to some families, but hypothetically important to others.
9. The IFSP was not important.
10. African American families' service utilization hours were greater than those of non-African American families because where they lived meant more center-based (i.e., intensive) services were provided.

This study found, first, that the participating African American mothers handled their parenting of a child with special needs with a positive attitude and by acquiring knowledge about services. Although the direct benefits of mothers' being positive have not been noted in the literature, this phenomenon is almost axiomatic. The importance of information to families has been well-documented (e.g., Gowen, Christy, & Sparling, 1993; Sontag & Schacht, 1993).

The second finding was that an ecological effect (Bronfenbrenner, 1979) was in place, with fathers' being involved with their children (even if they were not in the home), with family members other than the mother being involved, and with the church supporting some mothers. Our finding about continued paternal involvement supports research from two decades ago in which African Americans raised in female-headed households reported that their fathers continued to play an important role in their lives (Morris, 1977). The finding about extended-family involvement parallels Hale's (1982) study of African American grandmothers. The third of these supports, the church, has been defined as an expansion of the extended family (Turner & Alston, 1992) and an important support to African American families (Rogers-Dulan & Blacher, 1995). These family and community influences, therefore, substantiate results from previous investigations.

The third finding was that the way services were provided—not just whether services were in place—made a difference. The data showed that services are primarily child-oriented, which has been reported as true for families in general in this case study (McWilliam, Tocci, et al., 1995). Mothers' positive views of their service providers corroborates previous studies in which families have been shown to be very satisfied, above all with their primary service provider (McWilliam, Harbin, et al., 1995; McWilliam, Lang, et al., 1995). African American mothers'

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reactions to the race of the primary service provider, which were found to be salient in a few situations, is an area deserving further study. The unimportance of the IFSP or IEP confirms Harry's (1995) findings that the early intervention culture (our term) emphasized the actual document rather than parents' participation in its development. The final service-related issue we uncovered, that African American families received more service time than did non-African American families, contradicts findings from the larger study (N = 133), where no statistically significant differences were found in the mean hours provided to Caucasians (1.82), African Americans (1.71), or children from other races (1.19; Kochanek & Buka, in press).

As interpreted through cultural model theory, these results show that shared meanings (i.e., patterns of beliefs) could be detected within this small group of mothers. Some of the strengths found often in African American families (e.g., support of extended family, support of church, positive attitude) were discovered to be important tools for the families in this study. The interaction of families' use of center-based services, community, and ethnicity, resulting in more hours of service for the children, needs to be explored further.

Support to Families

Families obtain support from service providers and from other families.

1. Families refer to professionals as "friends more than professionals."
2. Families like having one or more other parents to talk to, but not always in groups.

Families' perceptions of professionals are discussed in the section on Family-Service Provider Relationships. The finding that families felt they received support from other families is consistent with other research (and with our earlier reported finding from the mixed-methods

analysis incorporating family characteristics), as is the fact that formal groups might not always be the form in which support is most effective (e.g., Affleck, Tennen, Rowe, Roscher, & Walker, 1989).

Families' Reflections

Families identified (a) access to information, (b) support from other parents, and (c) service coordination as the basic elements for smooth service use.

These elements interacted with family, service provider, and program characteristics to affect service use. These findings reflect some of the results of previous studies (e.g., Able-Boone, Goodwin, Sandall, Gordon, & Martin, 1992; McWilliam, Lang, et al., 1995; Sontag & Schacht, 1993). The study does emphasize the importance of providing information to families—how it is provided, who provides it, and when as well as how often it is provided. Data from numerous sources and projects within the Early Childhood Research Institute: Service Utilization suggest that families are primarily offered options about child-oriented services (see McWilliam, Tocci, & Harbin, 1995).

Study findings, therefore, are first identified from a mixture of data types. These results deal with families' reactions to services, transitions, service settings, the focus or orientation of services, control over services, psychological well-being, and support. Further analyses produced findings about the family-service provider relationship, African American mothers' cultural models, support to families, and families' reflection on services. Professionals' provision of services provided the second major area of results.

Professionals' Provision of Services

Professionals reflected on their services, demonstrated family-centered service provision, wrote IFSPs and IEPs, dealt with interagency collaboration, coordinated services, and used different service delivery models. For the sake of brevity, these findings are simply listed, with a general discussion following.

Service Providers' Reflections

Professionals generally believe they are doing a good job, and families strengthen that belief, even when professionals do not use recommended practices.

1. Service providers report being more family-centered than perhaps they are.
2. Interagency collaboration is reported to be successful.
3. Service providers want families to take a more active role in development of the IFSP, but the do not provide families with a structure to do so.
4. Effective service providers are reported to be nonjudgmental, down to earth, unconcerned about maintaining a professional-client distance, and flexible.
5. Insufficient funding causes gaps in servive delivery.
6. There is a shortage of specialized therapists, a problem exacerbated by third-party restrictions on models of therapists' service delivery.
7. The best thing about working in early intervention is contact with children and families.
8. The worst thing is the paperwork and bureacracy.

Family-Centered Service Provision

Service Providers' Constructed Meanings

The stories of six service providers might reflect an early intervention culture that has developed with regard to professionals' approaches to families,.

Five related components constitute important dimensions of family-centered practice:

1. A positive approach (see the bright side of children and families)
2. Responsiveness (listening and acting)
3. Orientation to the family (enquiring about and discussing parent-level concerns and priorities)
4. Friendliness or rapport (treating families informally and naturally)
5. Sensitivity (putting themselves in parents' shoes).

Orientation of Services

Services are Child-Oriented and Families Like Them That Way, But Why?

1. From information about the program, through assessment and IFSP/IEP development, to service delivery, early intervention programs convey that they focus primarily on a single member of the family—the child with disabilities.
2. Families learn early on that the business of early intervention is therapy and instruction for their child.
3. Families retain cultural models of self-reliance and apply them to taciturnity with service providers when it comes to discussing parent-level needs.

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4. Service providers who open the door appropriately to parent-level needs are able to address such needs.
5. Parents with no exposure to a family-centered program do not consider family-centered practices pertinent.

IFSP/IEP

For intervention, the IFSP/IEP is reported to be quite useless.

1. Service providers try to give families an active role, but they have no structure for doing so.
2. Some professionals decide on IFSP/IEP outcomes/goals before the meeting with the family.
3. Families and service providers treat the IFSP/IEP as something to be tolerated, suggesting the meeting and document are not being used as opportunities to forge stronger relationships with families.

Interagency Collaboration

Agencies work together more than they used to, but communities still face significant challenges in collaboration.

1. Staff consistency (i.e., low turnover) is important.
2. When primary service providers contact other agencies for families and smooth out conflicts between families and personnel from other agencies, interagency collaboration is enhanced.
3. We found the following barriers to collaboration: distrust among agencies, scheduling problems preventing communication, lack of information dissemination among agencies,

agencies not soliciting or listening to other professionals' viewpoints, staff turnover, nonparticipation in meetings, and differences in agency philosophies.

Service Coordination

Service coordination occurs at two levels: organization□ of existing services and alignment of new and different options from the existing service(s).

1. The former generally works much better than the latter.
2. The closer to the family the service coordinator is, the better organized existing services are.
3. The service coordinator's separation from the primary service does not result in successful alignment of new and different options.
4. A philosophical question still remains about the relative desirability and undesirability of a transdisciplinary model, where the primary service provider also provides service coordination but where this person might not offer the family new and different resources.
5. The role of the Part H service coordinator is unclear: Responsibilities ranged from weekly contact for various types of support to sporadic, formal contact (e.g., signing the mailed IFSP).
6. Many families were unable to name their official service coordinator.
7. Service coordination became particularly important at the transition from infant-toddler services to preschool services.
8. Service coordination was not available to preschoolers with disabilities and their families.

9. Family-centered service providers organize existing services even if they are not the official service coordinators.

10. In early intervention discourse, service coordination has become an umbrella term for any "indirect" services (e.g., meeting with other professionals about a family, getting information for a family, and even consulting with the parent about the child). Because it is listed in policy as a service, professionals can use it to justify activities they believe are appropriate but that might not be condoned by their agency or funding source as "direct" service.

11. Service providers report that gaps in services are caused by insufficient funding, especially for personnel, and especially for developmental therapists (OTs, PTs, SLPs).

Service Delivery Settings

Home-, Classroom-, and Clinic-Based

1. Home-based services result in the closest relationships between families and service providers.

2. Families see classroom-based services as appropriate when the child turns 3.

3. In some communities, families have to take their children to offices/clinics to receive early intervention services, which means that at least one parent must be available to take the child.

4. Clinic-based models tend to be multidisciplinary, meaning either the family has to take the child numerous times a week or the child has to "receive treatment" for a long time.

5. All service delivery models can involve a *tennis lesson* approach (weekly 30- to 60-minute sessions of direct, hands-on, one-on-one instruction or therapy) to early intervention and all can involve a consultative, integrated approach.

Specialized Services

1. Children receive many separate therapies—separate in terms of individual therapists, agencies, and locations.
2. Families using private therapy have even less chance of having specialized services integrated into everyday routines.
3. Shortage is especially problematic in rural communities.
4. The shortage of specialized therapists is compounded by insufficient funds, insufficient personnel available, and reimbursement restrictions on how they can practice.
5. The interdisciplinary and multidisciplinary models are commonly used, and the transdisciplinary model is rarely used.

Discussion

Findings about professionals' provision of services strongly reflect (a) a predominant child versus family orientation□ of services, (b) a generally positive approach to families (even if they do not fully concern themselves with the entire family), (c) a mainly disjointed and segregated (including multidisciplinary) way of working with other professionals, (d) reasonably effective coordination (if not integration) of existing services, (e) poor provision of information about resources outside the formal early intervention/preschool programs, (f) a heavy reliance on therapists (occupational, physical, and speech-language), and (g) dependence on direct, hands-on treatment in short blasts (e.g., weekly instruction or therapy). These findings point to areas for improvement through personnel development, management, policy, and research. Nevertheless, we should never forget that families appreciate the services, that professionals are overwhelmingly

kind and positive about the children and families, and that basic services appear to be in place when children are identified as being in need. These fundamental elements are indeed important as the field strives towards conceptually logical and validated practices.

References

Able-Boone, H., Goodwin, L. D., Sandall, S. R., Gordon, N., & Martin, D. G. (1992). Consumer based early intervention services. Journal of Early Intervention, 16, 201-209.

Affleck, G., Tennen, H., Rowe, J., Roscher, B., & Walker, L. (1989). Effects of formal support on mothers' adaptation to the hospital-to-home transition of high-risk infants: The benefits and costs of helping. Child Development, 60, 488-501.

Brinckerhoff, J. L., & Vincent, L. J. (1986). Increasing parental decision-making at the individualized educational program meeting. Journal of the Division for Early Childhood. 11, 46-58.

Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge: Harvard University Press.

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98, 310-357.

Davis, H., & Rushton, R. (1991). Counselling and supporting parents of children with developmental delay: A research evaluation. *Journal of Mental Deficiency Research, 35*(2), 89-112.

Devellis, R. F., Devellis, B. M., Revicki, D. A., Lurie, S. J., Runyan, D. K., & Bristol, M. (1985). Development and validation of the Child Improvement Locus of Control Scales. Journal of Social and Clinical Psychology, 3, 307-324.

Dunst, C. J., Jenkins, V., & Trivette, C. (1984). Family Support Scale: Reliability and validity. Journal of Individual, Family, and Community Wellness, 1(4), 45-52.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine.

Gowen, J. W., Christy, D. S., & Sparling, J. (1993). Informational needs of parents of young children with special needs. *Journal of Early Intervention, 17*, 194-210.

Hale, J. (1982). Black children: Their roots, culture, and learning styles. Provo, UT: Brigham Young University Press.

Harbin, G., & Kochanek, T. (1993). Early childhood research institute: Service utilization. Grant proposal to the U.S. Department of Education. Chapel Hill, NC: Frank Porter Graham Child Development Center.

Harbin, G. L., & Kochanek, T. (1998). Early childhood research institute: Service utilization: Final report. Chapel Hill, NC: Frank Porter Graham Child Development Center.

Holloway, S. D., & Fuller, B. (1992). The great child-care experiment: What are the lessons for school improvement? Educational Researcher, 21(7), 12-19.

Kochanek, T. T., & Buka, S. L. (in press). Patterns of early intervention service utilization: Significant child, maternal, and service provider factors. *Journal of Early Intervention.*

March, J., & Olsen, J. (1984). The new institutionalism: Organizational factors in political life. American Political Science review, 78, 734-749.

McCubbin, H. I., & Patterson, J. M. (1982). Family adaptation to crises. In H. I. McCubbin, A. E. Cauble, & J. M. Patterson (Eds.), Family stress, coping, and social support (pp. 26-47). Springfield, IL: Charles C Thomas.

McWilliam, R. A., Harbin, G. L., Porter, P., Vandiviere, P., Mittal, M., & Munn, D. (1995). An evaluation of family-centered coordinated Part H services in North Carolina: Part 1–

family-centered service provision. Frank Porter Graham Child Development Center, University of North Carolina, Chapel Hill, NC.

McWilliam, R. A., Lang, L., Vandiviere, P., Angell, R., Collins, L., & Underdown, G. (1995). Satisfaction and struggles: Family perceptions of early intervention services. *Journal of Early Intervention, 19,* 43-60.

McWilliam, R. A., Tocci, L., & Harbin, G. (1995). Services are child-oriented, and families like it that way–But why? Early Childhood Research Institute on Service Utilization, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Morris, R. B. (1977). Strengths of the black community: An investigation of the black community and broken homes. Dissertation Abstracts Int., 38.

Odom, S. L., McLean, M. E., Johnson, L. J., & LaMontagne, M. J. (1995). Recommended practices in early childhood special education: Validation and current use. *Journal of Early Intervention, 1,* 1-17.

Patton, M. Q. (1990). Qualitative evaluation and research methods. (2nd ed.). Newbury Park, CA: Sage.

Rogers-Dulan, J. , & Blacher, J. (1995). African American families, religion, and disability: A conceptual framework. Mental Retardation, 33, 226-238.

Sontag, J. C., & Schacht, R. (1993). Family diversity and patterns of service utilization in early intervention. Journal of Early Intervention, 17, 431-444.

Turner, W. L. , & Alston, R. J. (1992). The role of the family in psychosocial adaptation to physical disabilities for African Americans. Journal of the National Medical Association, 86, 915-921.

Yin, R. K. (1989) Case study research: Design and methods (2nd ed.). Newbury Park, CA: Sage.